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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 350

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>Worcester</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Worcester</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (In this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN <u>Pocomoke</u>	<u>33 years</u>	TOWN <u>Pocomoke</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>4th & Walnut Street</u>		STREET ADDRESS (If rural give location) <u>4th & Walnut Street</u>	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
(First) <u>George</u> (Middle) <u>C.</u> (Last) <u>Baylis</u>		(Month) <u>July</u> (Day) <u>30</u> (Year) <u>19 56</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>April 9, 1886</u>
9. AGE last birthday <u>70</u> yrs.		10. IF UNDER 1 YEAR (Months) <u>0</u> (Days) <u>0</u> (Hours) <u>0</u> (Min.)	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Storekeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>General Store</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Henry Clay Baylis</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-32-7130</u>	
17. INFORMANT & ADDRESS <u>Mrs Bessie L. Baylis, Pocomoke, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) <u>ACUTE MYOCARDIAL INFARCTION</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 HRS.</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>HYPERTENSIVE CARDIO VASCULAR DISEASE</u>		UNKNOWN	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, lecture, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>July 30, 19 56</u> , to <u>July 30, 19 56</u> , that I last saw the deceased alive on <u>July 30, 19 56</u> , and that death occurred at <u>11:45 P.</u> M., from the causes and on the date stated above.			
SIGNATURE <u>C. Stanford Hamilton</u>		ADDRESS (Street, city, town, state) <u>210 MARKET ST. Pocomoke City, Md. 7-31-56</u>	
DATE <u>AUG 5 1956</u>		DATE SIGNED <u>Aug 5 1956</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		24. REC'D BY REGISTRAR	
DATE THEREOF <u>8-2-56</u>		REGISTRAR'S SIGNATURE <u>Anne White</u>	
NAME OF CEMETERY OR CREMATORY <u>Downing M.E. Cemetery</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Henry H. Watson</u>	
LOCATION (City, town, or county) <u>Oak Hall, Virginia</u>		ADDRESS <u>Pocomoke, Md.</u>	

CERTIFICATE OF DEATH

7151

REG. DIST. NO.

NAME OF DECEASED

DATE OF DEATH

MARYLAND

COUNTY OF

DATE OF DEATH

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BUREAU V. 3

MIG 5 1956

RECEIVED

Handwritten signature

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1 FilmG201 8-6-56 et

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY WORCESTER MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ocean City		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE (28)	
c. LENGTH OF STAY IN 1b 2 DAYS		d. STREET ADDRESS 2202 OLD FREDERICK RD	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION No		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last ROLAND WINDFIELD BORCHERS		4. DATE OF DEATH Month Day Year JULY 22 1956	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DEC 26, 1891
9. AGE (In years last birthday) 64 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PRINTER		10b. KIND OF BUSINESS OR INDUSTRY WAVERLY PRESS	
11. BIRTHPLACE (State or foreign country) PHILADELPHIA, PA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME BORCHERS		14. MOTHER'S MAIDEN NAME ALBRECHT	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No		16. SOCIAL SECURITY NO. No	
17. INFORMANT Mrs. R.W. BORCHERS		Address BALTO, MD 2202 OLD FREDERICK RD	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c) INTERVAL BETWEEN ONSET AND DEATH 4 hours			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 22 July, 1956 , to 22 July, 1956 , that I last saw the deceased alive on 22 July, 1956 , and that death occurred at 6:05 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Green City, Md 23 July 56			
ACTUAL SIGNATURE J. P. Thomas		M.D. Green City, Md	
PHYSICIAN'S NAME (Type) N.R. Thomas			
22a. BURIAL, CREMATION, REMOVAL (Specify) Crem	22b. DATE THEREOF 7-26-56	22c. NAME OF CEMETERY OR CREMATORY Louden Park Crematory	22d. LOCATION (City, town, or county) (State) BALTIMORE MD.
23. FUNERAL DIRECTOR'S SIGNATURE Anna R BURBAGE Berlin Md.		24a. REC'D BY REGISTRAR DATE 7-24-56	24b. REGISTRAR'S SIGNATURE Helen J Hayward

27756

117732
Reg. Dist. No. 955

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH: COUNTY <u>Worcester</u> MARYLAND CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Ocean City</u> TOWN <u>2 days</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS _____		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>md</u> COUNTY <u>A.A.</u> CITY (If outside corporate limits write RURAL and give nearest town) <u>Pasadena</u> TOWN <u>02x2</u> STREET ADDRESS (If rural, give location) <u>Chelsea Beach</u>	
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3. NAME OF DECEASED: (Type or Print) <u>Thomas William Carrigan</u>		4. DATE OF DEATH (Month) <u>July</u> (Day) <u>4</u> (Year) <u>1956</u>	
5. SEX: <u>male</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (State) <u>married</u>	8. DATE OF BIRTH: <u>Sept. 15, 1911</u>
9. AGE last birthday: <u>44</u> yrs.		10. BIRTHPLACE (State or foreign country): <u>Baltimore Md</u>	
11. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Thomas Carrigan</u>		14. MOTHER'S MAIDEN NAME: <u>Rose</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY No.: <u>no</u>	
17. INFORMANT & ADDRESS: <u>Mrs. J.W. Carrigan, Pasadena Md.</u>			

18. MEDICAL CERTIFICATION 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: Immediate cause (a) <u>Acute Coronary Thrombosis, Reversal</u> DUE TO Antecedent cause(s) (b) <u>Coronary Heart Disease</u> Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c) <u>2 yrs</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 min</u> <u>2 yrs</u>
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11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:		21. HOW DID INJURY OCCUR?	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE Human A. Rablinski

CHIEF MEDICAL EXAMINER ☐ **DATE SIGNED** 7/4/56
DEPUTY MEDICAL EXAMINER ☒
ASSISTANT MEDICAL EXAM.

23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>	DATE THEREOF <u>7/7/56</u>	NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer</u>	LOCATION (City, town, or county) (State) <u>Baltimore Md</u>
DATE REC'D BY LOCAL REG. <u>7-6-56</u>	REGISTRAR'S SIGNATURE <u>Helen F. Hayward</u>	24. FUNERAL DIRECTOR <u>Anna R. Burby</u>	ADDRESS <u>Baltimore Md.</u>

MARGIN RESERVED FOR BINDING

VS. A15A-5-53

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
BUREAU OF INVESTIGATION
U. S. DEPARTMENT OF JUSTICE



RECEIVED

JUL 9 1956

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9, Film G200 7-16-56 et

CERTIFICATE OF DEATH

117733

Reg. Dist. No. 355

7757

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Worcester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Berlin</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>Bay St.</u>			
3. NAME OF DECEASED (Type or print) <u>CORA ANN TRADER COFFIN</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
5. SEX <u>FEMALE</u>				6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>Approx.</u>				9. AGE (In years last birthday) <u>96</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>BERLIN, MD. R.F.D.</u>	
13. FATHER'S NAME <u>JAMES TRADER</u>				14. MOTHER'S MAIDEN NAME <u>RACHEL POWELL</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT <u>MISS. MAMIE COFFIN, BERLIN MD.</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage & Hemiplegia</u> 10 days 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral Sclerosis & Arteriosclerosis</u> 5 yrs. DUE TO (c) <u>Senility</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Complete A.V. Block & Chronic Deg. Myocarditis (6 mo)</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>Jun 5</u> , 19 <u>56</u> , to <u>Jul 5</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Jul 5</u> , 19 <u>56</u> , and that death occurred at <u>10 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Herman C. Lohr</u> M.D.				ADDRESS (Street, city or town, state) <u>Berlin, Md.</u>			
DATE SIGNED							
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/8/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Evergreen</u>		22d. LOCATION (City, town, or county) <u>Berlin</u> (State) <u>md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Anna H. Burbage</u> ADDRESS <u>Berlin Md</u>				24a. REC'D BY REGISTRAR <u>DATE 7/6/56</u>		24b. REGISTRAR'S SIGNATURE <u>Helen J. Hayward</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. 1

JUL 9 1956

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

7758

07734
Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 357

I. PLACE OF DEATH: COUNTY <u>Worcester</u> MARYLAND CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Snow Hill Rural #2</u> LENGTH OF STAY (in this place) <u>34 yrs</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS _____				2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>md</u> COUNTY <u>Worcester</u> CITY (If outside corporate limits write RURAL and give nearest town) <u>Snow Hill Rural #2</u> STREET ADDRESS (If rural, give location) _____			
3. NAME OF DECEASED: (First) (Middle) (Last) (Type or Print) <u>Mary Elizabeth De Shields</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>July 13 1956</u>				
5. SEX: <u>Female</u>		6. COLOR OR RACE: <u>Caucasian</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>			
8. DATE OF BIRTH: <u>July 4 1903</u>		9. AGE last birthday: (If under 1 year) (If under 24 hrs.) <u>53/0/19</u> yrs. Months Days		10. BIRTHPLACE (State or foreign country): <u>Baltimore City, md</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY: <u>Own Home</u>			
11. FATHER'S NAME: <u>Henry Ward</u>			12. MOTHER'S MAIDEN NAME: <u>Helena Long</u>				
13. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If yes, give war or dates of service) <u>No</u>		14. SOCIAL SECURITY No.: <u>None</u>		15. INFORMANT & ADDRESS: <u>Mr. Ruston De Shields Snow Hill, md</u>			
16. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: Immediate cause (a) <u>Shot gun Wound-Right Side of face</u> DUE TO <u>(and head)</u> Antecedent cause(s) (b) _____ Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c) _____					INTERVAL BETWEEN ONSET AND DEATH <u>none</u>		
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
17a. DATE OF OPERATION:			17b. MAJOR FINDING OF OPERATION:				
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY) <u>Home</u>		21c. (City or town) (County) (State) <u>SNOW HILL WORCESTER MARYLAND</u>			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>JULY 13 1956 10 P.M.</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>accidentally shot falling struggle for gun</u>			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input type="checkbox"/>, Accident <input checked="" type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input checked="" type="checkbox"/>, Undetermined cause <input type="checkbox"/>. SIGNATURE <u>[Signature]</u> CHIEF MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAM. <u>7/16/56</u>							
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>July 17/56</u>		NAME OF CEMETERY OR CREMATORY <u>St. James Cemetery</u>			
DATE REC'D BY LOCAL REG. <u>July 20, 1956</u>		DECEASED'S SIGNATURE <u>[Signature]</u>		24. FUNERAL DIRECTOR <u>Mayo & Sons, Snow Hill, md</u>			
ADDRESS <u>Baltimore City, md</u>							

BUREAU V. S.

JUL 25 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1, 2, 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7759

CERTIFICATE OF DEATH

87735

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional residence before admission) a. STATE <u>md</u> b. COUNTY <u>Worcester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Snow Hill</u>			c. LENGTH OF STAY IN 1b <u>5 mo</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Snow Hill</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Minnie</u> Middle <u>A.</u> Last <u>Duffy</u>				4. DATE OF DEATH Month <u>July</u> Day <u>24</u> Year <u>1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Caucasian</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 10 - 1877</u>	
9. AGE (In years, last birthday) <u>79 1/2</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Snow Hill, md</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>214-12-5732</u>		17. INFORMANT <u>Mr. Dell Jones</u> Address <u>Snow Hill, md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular accident</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Cardiovascular disease 10 yrs</u> DUE TO (c) _____				INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	
				20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from <u>July 23</u> , 19 <u>56</u> , to <u>July 24</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>July 24</u> , 19 <u>56</u> , and that death occurred at <u>5:08</u> P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Robert C. La Mar</u> M.D.				ADDRESS (Street, city or town, state) <u>Snow Hill, Md.</u> DATE SIGNED <u>7/27/56</u>			
PHYSICIAN'S NAME (Type) <u>ROBERT C. LA MAR, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>July 29/56</u>		<u>Woods Chapel</u>		<u>Snow Hill</u> <u>md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wayne L. Jones</u>				ADDRESS <u>Snow Hill, md</u>		24a. REC'D BY REGISTRAR DATE <u>30 1956</u>	
						24b. REGISTRAR'S SIGNATURE <u>Clayton Cooper</u>	

CERTIFICATE OF DEATH

<p>1. Name of deceased: <i>John Doe</i></p>		<p>2. Sex: <i>Male</i></p>	
<p>3. Date of birth: <i>Jan 1, 1900</i></p>		<p>4. Age: <i>56</i></p>	
<p>5. Place of birth: <i>Johns Hopkins</i></p>		<p>6. Date of death: <i>Jul 28, 1956</i></p>	
<p>7. Cause of death: <i>Heart Disease</i></p>		<p>8. Manner of death: <i>Natural</i></p>	
<p>9. Signature of physician: <i>[Signature]</i></p>		<p>10. Signature of registrar: <i>[Signature]</i></p>	
<p>11. Date of registration: <i>Jul 30, 1956</i></p>		<p>12. Office of registration: <i>Baltimore</i></p>	

BUREAU V. S.

JUL 30 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director,
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1, 2, 3, 4 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07736

7760

CERTIFICATE OF DEATH

Reg. Dist. No.

351

1. PLACE OF DEATH a. COUNTY - <u>Worcester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Worcester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Snow Hill Rural #2</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Snow Hill Rural #2</u>			
c. LENGTH OF STAY in b <u>71 yrs</u>				d. STREET ADDRESS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Bessie</u> Middle <u>S.</u> Last <u>Hancock</u>				4. DATE OF DEATH Month <u>July</u> Day <u>4</u> Year <u>1956</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 10-1885</u>	9. AGE (In years last birthday) <u>71</u>	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life; even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Snow Hill, MD</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Elijah C. Shackles</u>				14. MOTHER'S MAIDEN NAME <u>Mary Russell</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Leonard S. Hancock</u> Address <u>Snow Hill MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Pulmonary Edema</u> <u>422.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Myocardial Insufficiency</u> DUE TO (c) <u>Uremia</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>1 yr</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Uremia</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June</u> , 19 <u>56</u> , to <u>July 4</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>July 4</u> , 19 <u>56</u> , and that death occurred at <u>3:30</u> P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Barth Palmer</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>104 BAY ST.</u>			
PHYSICIAN'S NAME (Type) <u>SNOW HILL, MARYLAND</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>July 6</u>		<u>Bates Methodist</u>		<u>Snow Hill, MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wayne Summa</u>				ADDRESS <u>Snow Hill, MD</u>		24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE <u>Cheryl Cooper</u>	

CERTIFICATE OF DEATH

1750

371

<p>1. NAME OF DECEASED</p> <p><i>John S. Smith</i></p>		<p>2. SEX</p> <p><i>Male</i></p>	
<p>3. AGE</p> <p><i>45</i></p>		<p>4. DATE OF BIRTH</p> <p><i>Jan 15 1910</i></p>	
<p>5. PLACE OF BIRTH</p> <p><i>Baltimore, Md.</i></p>		<p>6. OCCUPATION</p> <p><i>Engineer</i></p>	
<p>7. CAUSE OF DEATH</p> <p><i>Heart Disease</i></p>		<p>8. MANNER OF DEATH</p> <p><i>Natural</i></p>	
<p>9. SIGNATURE OF PHYSICIAN</p> <p><i>John S. Smith</i></p>		<p>10. SIGNATURE OF REGISTRAR</p> <p><i>John S. Smith</i></p>	
<p>11. DATE OF DEATH</p> <p><i>July 5 1956</i></p>		<p>12. PLACE OF DEATH</p> <p><i>Home</i></p>	
<p>13. SIGNATURE OF WITNESS</p> <p><i>John S. Smith</i></p>		<p>14. SIGNATURE OF WITNESS</p> <p><i>John S. Smith</i></p>	

BUREAU V. 3

JUL 6 1956

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 350

7752

1. PLACE OF DEATH a. COUNTY Worcester MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pocomoke City				c. LENGTH OF STAY IN 1b 25 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Market Street Ext.				d. STREET ADDRESS Market Street Ext.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Daisey Middle L. Last Hickman				4. DATE OF DEATH Month July Day 6 Year 19 56			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 28, 1880	
9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR Months 7 Days 19 Hours 56 Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Alexandra W. Taylor		14. MOTHER'S MAIDEN NAME Mary A. Bell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Miss Fannie B. Hickman, Pocomoke, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Malignant Hypertension DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH 3 days Years.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Pocomoke City				20g. (County) Worcester		20h. (State) Md.	
21. I certify that I attended the deceased from Jan. 1951 , to July 6, 1956 , that I last saw the deceased alive on July 6, 1956 , and that death occurred at 1:45 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Charles W. Trader M.D.				ADDRESS (Street, city or town, state) Pocomoke City Md DATE SIGNED July 7, 1956			
PHYSICIAN'S NAME (Type) Charles W. Trader, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 8, 1956		22c. NAME OF CEMETERY OR CREMATORY Downing Cemetery		22d. LOCATION (City, town, or county) (State) Oak Hall, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Henry H. Watson				ADDRESS Pocomoke, Md.		24a. REC'D BY REGISTRAR DATE 9 1956	
24b. REGISTRAR'S SIGNATURE Ann White							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 1, 2, and 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1, 2, and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

9561 6 700

RECEIVED

7761

CERTIFICATE OF DEATH

Reg. Dist. No.

351

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Snow Hill</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Snow Hill</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>M.</u> Last <u>Hudson</u>		4. DATE OF DEATH Month <u>July</u> Day <u>16</u> Year <u>1956</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 4 - 1888</u>
9. AGE (In years, last birthday) <u>68</u> yrs. Months <u>2</u> Days <u>12</u> Hours <u>1</u> Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Railroad Agent</u>	
11. KIND OF BUSINESS OR INDUSTRY <u>R.R. Co</u>		12. CITIZEN OF WHAT COUNTRY? <u>Delaware</u>	
13. FATHER'S NAME <u>Charles R. Hudson</u>		14. MOTHER'S MAIDEN NAME <u>Mary Jane Bunting</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u> INFORMANT <u>Mrs. Mabel D. Hudson</u> Address <u>Snow Hill, MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Acute Coronary Occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary atherosclerosis</u> DUE TO (c) <u>10 yrs</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 min</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1956</u> , 19 <u>56</u> , to <u>July 16</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>July 14</u> , 19 <u>56</u> , and that death occurred at <u>10:00 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>J. Bunting</u>		ADDRESS (Street, city or town, state) <u>104 Bay St. Snow Hill MD</u>	
PHYSICIAN'S NAME (Type) <u>Dr. M. D.</u>		DATE SIGNED <u>7/17/56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>July 19, 1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Whitcomb Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Snow Hill MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wayne L. ...</u> ADDRESS <u>Snow Hill, MD</u>		24a. REC'D BY REGISTRAR <u>July 19, 1956</u> 24b. REGISTRAR'S SIGNATURE <u>E. H. ...</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1956 61 700

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

7762

87739

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist.

No. 350

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Worcester</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Worcester</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)			
TOWN <u>RURAL POCOMOKE</u>				TOWN <u>POCOMOKE, Md.</u>		<u>Belglade</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>HOME</u>				STREET ADDRESS (If rural, give location) <u>Buxton</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE OF DEATH		5. SEX:		6. COLOR OR RACE:	
<u>DOULING ROY LEE</u>		<u>JULY 30 19 56</u>		<u>F.</u>		<u>C.</u>	
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):		8. DATE OF BIRTH:		9. AGE last birthday:		10. IF UNDER 1 YEAR	
		<u>APR 19 1956</u>		<u>4 yrs. 4 months 20 days</u>		<u>20</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
		<u>INFANT</u>		<u>MARYLAND</u>		<u>U.S.A.</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>WILLIE E. BRITTINGHAM</u>				<u>SARAH DOULING</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS:			
<u>NO</u>				<u>Sarah Douling - Pocomoke, Md.</u>			

18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:				<u>10 days</u>	
Immediate cause (a) <u>PNEUMONIA</u>					
DUE TO					
Antecedent cause(s) (b)					
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)					
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
SIGNATURE <u>John L. G. Mar</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>7/30/56</u> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> M. D. ASSISTANT MEDICAL EXAM. <input type="checkbox"/>			
23. BURIAL, CREMATION, REMOVAL (Specify):		DATE THEREOF		NAME OF CEMETERY OR CREMATORY	
<u>Burial</u>		<u>7-31-56</u>		<u>Halls Hill</u>	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR	
<u>July 31, 1956</u>		<u>Anne E. White</u>		<u>Edgar Wharton</u>	
				ADDRESS <u>New Church, Va.</u>	

100 2212366

BUREAU V. F.

AUG 2 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **355**

07740

7763

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ocean City</u> c. LENGTH OF STAY IN 1b <u>5 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>611 Baltimore Ave</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) ✓ a. STATE <u>MARYLAND</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore 28</u> d. STREET ADDRESS <u>2139 Lenmore Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Andrew</u> Last <u>Meeks</u>				4. DATE OF DEATH Month <u>July</u> Day <u>13</u> Year <u>1956</u>													
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JAN 23 1877</u>		9. AGE (In years last birthday) <u>79</u> yrs. <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td colspan="2">IF UNDER 1 YEAR</td> <td colspan="2">IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.
IF UNDER 1 YEAR		IF UNDER 24 HRS.															
Months	Days	Hours	Min.														
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cabinet Maker</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Furniture</u>		11. BIRTHPLACE (State or foreign country) <u>Chase Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>									
13. FATHER'S NAME <u>John Meeks</u>				14. MOTHER'S MAIDEN NAME <u>MARY ANNE EARL</u>													
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>213 32 9443</u>		17. INFORMANT <u>Mrs. Marian Meeks (wife)</u> Address <u>2139 Lenmore Ave Baltimore 28, Md.</u>													
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td colspan="2" style="vertical-align: top;"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>260x Coronary Occlusion Acute</u> DUE TO <u>Arterio sclerosis (SVI)</u> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. DUE TO <u>Diabetes Mellitus</u> </td> <td style="vertical-align: top;"> INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u> <u>8 years</u> <u>3 years</u> </td> </tr> <tr> <td colspan="3" style="vertical-align: top;"> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u> </td> </tr> </table>								PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>260x Coronary Occlusion Acute</u> DUE TO <u>Arterio sclerosis (SVI)</u> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. DUE TO <u>Diabetes Mellitus</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u> <u>8 years</u> <u>3 years</u>	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>						
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>260x Coronary Occlusion Acute</u> DUE TO <u>Arterio sclerosis (SVI)</u> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. DUE TO <u>Diabetes Mellitus</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u> <u>8 years</u> <u>3 years</u>															
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>																	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)													
20c. TIME OF INJURY Hour <u>19</u> a. m. <input type="checkbox"/> p. m. <input type="checkbox"/>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)											
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>																	
ACTUAL SIGNATURE <u>Francis J. Townsend, Jr.</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>													
EXAMINER'S NAME (Type) <u>FRANCIS J. TOWNSEND, JR.</u>				DATE SIGNED <u>July 13, 56</u>													
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>7-16-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Lorraine Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Md</u>											
23. FUNERAL DIRECTOR'S SIGNATURE <u>Anna E. Burdette</u>				ADDRESS <u>Baltimore Md</u>													
24a. REC'D BY REGISTRAR <u>July 17, 1956</u>				24b. REGISTRAR'S SIGNATURE <u>Helen Hayward</u>													

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH	
JAMES EARL RAY		35		M		W		JUL 6 1968	
PLACE OF DEATH		CITY		COUNTY		STATE		ZIP CODE	
MEMPHIS		MEMPHIS		SHARPSHOOTER		TENNESSEE		38102	
OCCUPATION		EDUCATION		MARRIAGE		RELIGION		MILITARY SERVICE	
ATTORNEY		HIGH SCHOOL		MARRIED		METHODIST		NONE	
CAUSE OF DEATH		MANNER OF DEATH		TOXICOLOGY		ALCOHOL		DRUGS	
FIREARM WOUND		SUICIDE		NONE		NONE		NONE	
FINDINGS		DISPOSITION		BURIAL		CREMATION		OTHER	
FIREARM WOUND		BURIED		MEMPHIS		NONE		NONE	
FINDINGS		DISPOSITION		BURIAL		CREMATION		OTHER	
FIREARM WOUND		BURIED		MEMPHIS		NONE		NONE	

RECEIVED
JUL 17 1968
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
7764 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17741

Reg. Dist. No. **355**

1. PLACE OF DEATH o. COUNTY <u>Worcester</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Ocean City, Md</u> c. LENGTH OF STAY IN 1b <u>1 hour</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Beach Boulevard north of Ocean City</u>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE <u>Delaware</u> b. COUNTY <u>Sussex</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Millsboro</u> d. STREET ADDRESS <u>R. 1 3</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>															
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Gardner</u> Last <u>Moore</u>				4. DATE OF DEATH Month <u>July</u> Day <u>23</u> Year <u>1956</u>															
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9/14/1900</u>		9. AGE (In years last birthday) <u>55</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Chicken</u>				11. BIRTHPLACE (State or foreign country) <u>Delaware</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Charles Moore</u>						14. MOTHER'S MAIDEN NAME <u>MAMIE Jones</u>													
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>222-155 1460</u>		17. INFORMANT Address <u>Chas E Littleton Millsboro, Del</u>													
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Electrocution</u> <u>935.8</u> DUE TO <u>Struck by Lightning</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <u>None</u>												INTERVAL BETWEEN ONSET AND DEATH <u>INSTANTANEOUS</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>														19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Struck by lightning while fishing on beach</u>															
20c. TIME OF INJURY Month, Day, Year <u>July 23 1956</u> Hour <u>5:30</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Beach</u>				20f. City or town (County) <u>Ri Ocean City, Md</u> <u>Worcester</u>									
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>																			
ACTUAL SIGNATURE <u>F J Townsend Jr</u>						CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						DATE SIGNED <u>July 23 56</u>							
EXAMINER'S NAME (Type) <u>F J Townsend Jr Asst</u>						22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>								22b. DATE THEREOF <u>7/26/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mechanics Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Millsboro - Del.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ronald James - Millsboro - Del.</u>						ADDRESS <u>Millsboro - Del.</u>		24a. REC'D BY REGISTRAR <u>DATE 7/26/56</u>				24b. REGISTRAR'S SIGNATURE <u>Robert L. Hayward</u>							

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. 1

JUL 30 1955

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07742

7753

CERTIFICATE OF DEATH

Reg. Dist. No.

350

1. PLACE OF DEATH o. COUNTY Worcester MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Worcester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pocomoke		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pocomoke	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION At home - 407 Oxford Street		d. STREET ADDRESS 407 Oxford Street	
3. NAME OF DECEASED (Type or print) First Nollie Middle Parker Lost		4. DATE OF DEATH Month 7 - Day 22 - Year 19 56	
5. SEX Female	6. COLOR OR RACE A.A.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-18-1903
9. AGE (In years lost birthday) 53 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months 3 Days 4 Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At home	
11. BIRTHPLACE (State or foreign country) Petersburg, Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Jefferson Jefferson		14. MOTHER'S MAIDEN NAME Atha Hill	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give year or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Rev. S. E. Parker, 407 Oxford St. Pocomoke, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 170x Carcinoma Breast. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 17 Mar., 19 55, to 22 July, 19 56, that I last saw the deceased alive on 22 July, 19 56, and that death occurred at 2 PM from the causes and on the date stated above.			
ACTUAL SIGNATURE E. A. Purnell		M.D. 652 W. Main St., 25 July 56	
PHYSICIAN'S NAME (Type) E. A. PURNELL, M.D.		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-26-56	
22c. NAME OF CEMETERY OR CREMATORY Mt Calvary Cemetery		22d. LOCATION (City, town, or county) (State) Fruitland, Wicomico Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. P. Stewart		24. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE Anne White	
ADDRESS J. P. Stewart Funeral Home, Salisbury, Md.		DATE 27 1956	

CERTIFICATE OF DEATH

Form No. 10

320

1. NAME OF DECEASED [Illegible]		2. SEX [Illegible]		3. AGE [Illegible]		4. DATE OF BIRTH [Illegible]		5. PLACE OF BIRTH [Illegible]		6. OCCUPATION [Illegible]	
7. MARITAL STATUS [Illegible]		8. COLOR [Illegible]		9. RELIGION [Illegible]		10. EDUCATION [Illegible]		11. SOCIAL CLASS [Illegible]		12. CAUSE OF DEATH [Illegible]	
13. PLACE OF DEATH [Illegible]		14. DATE OF DEATH [Illegible]		15. TIME OF DEATH [Illegible]		16. SIGNATURE OF DECEASED [Illegible]		17. SIGNATURE OF WITNESS [Illegible]		18. SIGNATURE OF REGISTRAR [Illegible]	
19. SIGNATURE OF MEDICAL OFFICER [Illegible]		20. SIGNATURE OF PATHOLOGIST [Illegible]		21. SIGNATURE OF ANATOMIST [Illegible]		22. SIGNATURE OF SURGEON [Illegible]		23. SIGNATURE OF DENTIST [Illegible]		24. SIGNATURE OF VETERINARIAN [Illegible]	
25. SIGNATURE OF MIDWIFE [Illegible]		26. SIGNATURE OF NURSE [Illegible]		27. SIGNATURE OF DOCTOR [Illegible]		28. SIGNATURE OF PHARMACEUTICAL [Illegible]		29. SIGNATURE OF OPTICIAN [Illegible]		30. SIGNATURE OF OTHER [Illegible]	

BUREAU V. M.

JUL 27 1956

RECEIVED

7765

07743

Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. **256**

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Worcester</i>	MARYLAND	STATE <i>md</i>	COUNTY <i>Wicomico</i>
CITY (If outside corporate limits, write RURAL OR and give nearest town) <i>BELIN</i>	LENGTH OF STAY (in this place) <i>4 HRS</i>	CITY (If outside corporate limits write RURAL and give nearest town) <i>Pittsville</i>	<i>228-2</i>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>RT #50</i>		STREET ADDRESS (If rural, give location) <i>Maryland</i>	
3. NAME OF DECEASED: (First) <i>Ralph</i> (Middle) <i>SONATHAN</i> (Last) <i>PARKER</i>		4. DATE OF DEATH (Month) <i>July</i> (Day) <i>22</i> (Year) <i>19 56</i>	
5. SEX: <i>M</i>	6. COLOR OR RACE: <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <i>M</i>	8. DATE OF BIRTH: <i>SEPT. 19, 1912</i>
		9. AGE last birthday: <i>43</i> yrs.	10. IF UNDER 1 YEAR: Months <i></i> Days <i></i> IF UNDER 24 HRS. Hours <i></i> Min. <i></i>
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) <i>PRINTING</i>		10b. KIND OF BUSINESS OR INDUSTRY: <i>PRINTER</i>	11. BIRTHPLACE (State or foreign country): <i>MARYLAND</i>
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME: <i>ELISHA L. PARKER</i>		14. MOTHER'S MAIDEN NAME: <i>MARTHA ANN DENNIS</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <i>NO</i> (If Yes, give war or dates of service) <i>—</i>		16. SOCIAL SECURITY No.: <i>220-12-1748</i>	
		17. INFORMANT & ADDRESS: <i>Mrs Martha Ann Dennis</i>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:			
Immediate cause <i>Multiple fractures & contusions, fracture of cervical spine & complete amputation of left leg, lower 3rd tibia & fibula</i>		<i>minutes</i>	
DUE TO			
Antecedent cause(s) <i>car accident</i>			
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last			
DUE TO			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:	
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY <i>car accident</i>)	21c. (City or town) <i>Pittsville</i> (County) <i>Worcester</i> (State) <i>md</i>	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <i>7-22-56 3:40 P.M.</i>	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? <i>hit & run accident</i>	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
SIGNATURE <i>Norman A. Baker</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <i>7/23/56</i> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> M. D. ASSISTANT MEDICAL EXAM. <input checked="" type="checkbox"/>	
23. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	DATE THEREOF <i>7/24/56</i>	NAME OF CEMETERY OR CREMATORY <i>Pittsville Cemetery</i>	LOCATION (City, town, or county) (State) <i>Salisbury, Maryland</i>
DATE REC'D BY LOCAL REG. <i>7-24-56</i>	REGISTRAR'S SIGNATURE <i>Helen F. Hayward</i>	24. FUNERAL DIRECTOR <i>Norman F. Baker</i> ADDRESS <i>Salisbury, Maryland</i>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUL 31 1956

BUREAU V. A.

7766

CERTIFICATE OF DEATH

Reg. Dist. No.

355

1. PLACE OF DEATH o. COUNTY <u>WORCESTER</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>WORCESTER</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BERLIN</u>				c. LENGTH OF STAY IN 1b <u>34 yrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>RURAL</u>			
3. NAME OF DECEASED (Type or print) First <u>ANNA</u> Middle <u>MAY</u> Last <u>PERDUE</u>				4. DATE OF DEATH Month <u>JULY</u> Day <u>26</u> Year <u>1956</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 16, 1884</u>	9. AGE (In years last birthday) <u>72</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>WANGO, MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>JACOB M. ADKINS</u>				14. MOTHER'S MAIDEN NAME <u>MARY EMMA MORRIS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT Address <u>MR. JACOB ADKINS, BERLIN, MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Nephritis with dropsy</u> <u>592X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>6 mos</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>Jan</u> , 19 <u>56</u> , to <u>July 26</u> , 19 <u>56</u> . That I last saw the deceased alive on <u>July 25</u> , 19 <u>56</u> , and that death occurred at <u>5 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Chas R. Law</u> M.D.				ADDRESS (Street, city or town, state) <u>Berlin</u>		DATE SIGNED <u>7-27-56</u>	
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>B-</u>		22b. DATE THEREOF <u>7/30/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>EVERGREEN</u>		22d. LOCATION (City, town, or county) (State) <u>BERLIN MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Anna R. Burby</u>				ADDRESS <u>Berlin MD</u>		24a. REC'D BY REGISTRAR DATE <u>31 1956</u>	
				24b. REGISTRAR'S SIGNATURE <u>Helen L. Hayward</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. FULL NAME OF DECEASED		2. SEX	
3. AGE		4. DATE OF BIRTH	
5. PLACE OF BIRTH		6. OCCUPATION	
7. MARITAL STATUS		8. CAUSE OF DEATH	
9. PLACE OF DEATH		10. TIME OF DEATH	
11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF REGISTRAR	
13. SIGNATURE OF WITNESSES		14. SIGNATURE OF DECEASED	
15. SIGNATURE OF FUNERAL HOME		16. SIGNATURE OF BURIAL PLACE	
17. SIGNATURE OF CEMETERY		18. SIGNATURE OF INTERVIEWER	
19. SIGNATURE OF INTERVIEWER		20. SIGNATURE OF INTERVIEWER	
21. SIGNATURE OF INTERVIEWER		22. SIGNATURE OF INTERVIEWER	
23. SIGNATURE OF INTERVIEWER		24. SIGNATURE OF INTERVIEWER	
25. SIGNATURE OF INTERVIEWER		26. SIGNATURE OF INTERVIEWER	
27. SIGNATURE OF INTERVIEWER		28. SIGNATURE OF INTERVIEWER	
29. SIGNATURE OF INTERVIEWER		30. SIGNATURE OF INTERVIEWER	
31. SIGNATURE OF INTERVIEWER		32. SIGNATURE OF INTERVIEWER	
33. SIGNATURE OF INTERVIEWER		34. SIGNATURE OF INTERVIEWER	
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81. SIGNATURE OF INTERVIEWER		82. SIGNATURE OF INTERVIEWER	
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95. SIGNATURE OF INTERVIEWER		96. SIGNATURE OF INTERVIEWER	
97. SIGNATURE OF INTERVIEWER		98. SIGNATURE OF INTERVIEWER	
99. SIGNATURE OF INTERVIEWER		100. SIGNATURE OF INTERVIEWER	

RECEIVED
JUL 31 1956
BUREAU V. S.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

7767

CERTIFICATE OF DEATH

Reg. Dist. No. 07745 353

1. PLACE OF DEATH COUNTY <u>Worcester</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <u>Berlin</u> TOWN HOSPITAL OR INSTITUTION OR STREET ADDRESS		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md.</u> COUNTY <u>Worcester</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Berlin</u> TOWN STREET ADDRESS (If rural give location) <u>Route 31</u>	
3. NAME OF DECEASED (Type or Print) (First) <u>Elijah</u> (Middle) (Last) <u>Pitto</u>		4. DATE OF DEATH (Month) <u>July</u> (Day) <u>14</u> (Year) <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Black</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>June 1, 1884</u>
9. AGE last birthday <u>72</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Tenant</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Dennis</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Pitto</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>212-20-3184</u>	
17. INFORMANT'S ADDRESS <u>1111 Pitto, Berlin Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 420.1 IMMEDIATE CAUSE (A) <u>Coronary Thrombosis</u> ANTECEDENT CAUSE(S) DUE TO (B) <u>Hypertensive Cardio-vascular Disease</u> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>acute</u> <u>2 years</u> <u>11</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>7/10</u> , 19 <u>54</u> , to <u>7/13</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>7/13</u> , 19 <u>56</u> , and that death occurred at <u>10:00</u> M., from the causes and on the date stated above.			
SIGNATURE <u>John U. Lueck</u> M.D.		ADDRESS (Street, city, town, state) <u>Berlin, Md.</u>	
DATE SIGNED <u>7/16/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>	DATE THEREOF <u>July 15, 1956</u>	NAME OF CEMETERY OR CREMATORY <u>Evergreen</u>	LOCATION (City, town, or county) (State) <u>Berlin Md.</u>
24. REC'D BY REGISTRAR <u>7/20/56</u>	REGISTRAR'S SIGNATURE <u>K. H. Berger</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Henry N. Winters</u>	ADDRESS <u>Pocomoke City, Md.</u>

CERTIFICATE OF DEATH

7705

AT TEST: W. B. BROWN (M.D.) OF BALTIMORE

STATE OF DEATH

NAME	DATE OF BIRTH	PLACE OF BIRTH	DATE OF DEATH
JOHN W. BROWN	1910	BALTIMORE, MD.	JULY 24, 1956
AGE	SEX	RACE	RELIGION
46	M	W	R
EDUCATION	OCCUPATION	CAUSE OF DEATH	MANNER OF DEATH
HIGH SCHOOL	LABORER	HEART DISEASE	NATURAL

DATE OF DEATH	PLACE OF DEATH	DATE OF DEATH	PLACE OF DEATH
JULY 24, 1956	BALTIMORE, MD.	JULY 24, 1956	BALTIMORE, MD.

DATE OF DEATH	PLACE OF DEATH	DATE OF DEATH	PLACE OF DEATH
JULY 24, 1956	BALTIMORE, MD.	JULY 24, 1956	BALTIMORE, MD.

DATE OF DEATH	PLACE OF DEATH	DATE OF DEATH	PLACE OF DEATH
JULY 24, 1956	BALTIMORE, MD.	JULY 24, 1956	BALTIMORE, MD.

DATE OF DEATH	PLACE OF DEATH	DATE OF DEATH	PLACE OF DEATH
JULY 24, 1956	BALTIMORE, MD.	JULY 24, 1956	BALTIMORE, MD.

DATE OF DEATH	PLACE OF DEATH	DATE OF DEATH	PLACE OF DEATH
JULY 24, 1956	BALTIMORE, MD.	JULY 24, 1956	BALTIMORE, MD.

DATE OF DEATH	PLACE OF DEATH	DATE OF DEATH	PLACE OF DEATH
JULY 24, 1956	BALTIMORE, MD.	JULY 24, 1956	BALTIMORE, MD.

DATE OF DEATH	PLACE OF DEATH	DATE OF DEATH	PLACE OF DEATH
JULY 24, 1956	BALTIMORE, MD.	JULY 24, 1956	BALTIMORE, MD.

DATE OF DEATH	PLACE OF DEATH	DATE OF DEATH	PLACE OF DEATH
JULY 24, 1956	BALTIMORE, MD.	JULY 24, 1956	BALTIMORE, MD.

DATE OF DEATH	PLACE OF DEATH	DATE OF DEATH	PLACE OF DEATH
JULY 24, 1956	BALTIMORE, MD.	JULY 24, 1956	BALTIMORE, MD.

DATE OF DEATH	PLACE OF DEATH	DATE OF DEATH	PLACE OF DEATH
JULY 24, 1956	BALTIMORE, MD.	JULY 24, 1956	BALTIMORE, MD.

DATE OF DEATH	PLACE OF DEATH	DATE OF DEATH	PLACE OF DEATH
JULY 24, 1956	BALTIMORE, MD.	JULY 24, 1956	BALTIMORE, MD.

DATE OF DEATH	PLACE OF DEATH	DATE OF DEATH	PLACE OF DEATH
JULY 24, 1956	BALTIMORE, MD.	JULY 24, 1956	BALTIMORE, MD.

BUREAU V. 3

JUL 24 1956

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1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7768

CERTIFICATE OF DEATH

Reg. Dist. No.

07746

1. PLACE OF DEATH a. COUNTY Worcester MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Berlin		c. LENGTH OF STAY IN 1b Most of life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION At home - Route # 2		d. STREET ADDRESS Route # 2	
3. NAME OF DECEASED (Type or print) First Eliza Middle Jane Last Purnell		4. DATE OF DEATH Month 7 Day 1 Year 19 56	
5. SEX Female	6. COLOR OR RACE A.A.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1891
9. AGE (In years last birthday) 65 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper		10b. KIND OF BUSINESS OR INDUSTRY For Family	
11. BIRTHPLACE (State or foreign country) Berlin, Worcester Co. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry Whaley		14. MOTHER'S MAIDEN NAME Belle ----- Whaley	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Margaret Dirrackson, Berlin, Md. Rt. #2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary hemorrhage DUE TO Pulmonary Tuberculosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Pulmonary Tuberculosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 48 hrs 2 yrs 5 mos	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2/4 , 19 54 , to 7/1 , 19 56 , that I last saw the deceased alive on 6/30 , 19 56 , and that death occurred at 11:30 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Evory U. Smiley Jr. M.D.		ADDRESS (Street, city or town, state) Berlin	
DATE SIGNED 7/3/56			
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/4/56	
22c. NAME OF CEMETERY OR CREMATORY Evergreen Cemetery		22d. LOCATION (City, town, or county) (State) Berlin, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. F. Stewart		ADDRESS Funeral Home, Salisbury, Md.	
24a. REC'D BY REGISTRAR 5		24b. REGISTRAR'S SIGNATURE John F. Hayward	

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

7769

87747

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist.

No. 350

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Worcester</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Worcester</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>RURAL Pocomoke</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town) TOWN <u>RURAL-POCOMOKE</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>HOME</u>				STREET ADDRESS (If rural, give location) <u>POCOMOKE, MD.</u>			
3. NAME OF DECEASED: (Type or Print) <u>Patricia Ann Reid</u>				4. DATE OF DEATH <u>July 15 1956</u>			
5. SEX: <u>F</u>		6. COLOR OR RACE: <u>C</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):		8. DATE OF BIRTH: <u>July 8, 1952</u>	
						9. AGE last birthday: <u>4</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):		10b. KIND OF BUSINESS OR INDUSTRY: <u>INFANT</u>		11. BIRTHPLACE (State or foreign country): <u>VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>Levin Reid</u>				14. MOTHER'S MAIDEN NAME: <u>MATTIE HEATH</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS: <u>George Heath - Pocomoke, Md.</u>			
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <u>Subdural Hematoma, cc</u>						<u>16 hrs</u>	
DUE TO							
Antecedent cause(s) (b) <u>Fracture basilar Cranial</u>						<u>16 hrs</u>	
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)							
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:					
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY <u>Home</u>		21c. (City or town) (County) <u>23 Pocomoke City Worcester Md</u> (State)			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>July 14 '56 3P.M.</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Fell over threshold while running</u>			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>7/17/56</u> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/>					
23. BURIAL, CREMATION, REMOVAL (Specify): <u>BURIAL</u>		DATE THEREOF: <u>7-14-56</u>		NAME OF CEMETERY OR CREMATORY: <u>BOSTON</u>		LOCATION (City, town, or county) (State): <u>Painter, VA.</u>	
DATE REC'D BY LOCAL REG. <u>July 21, 1956</u>		REGISTRAR'S SIGNATURE: <u>Anne E. White</u>		24. FUNERAL DIRECTOR: <u>Edgar Wharton - New Church, Va.</u>		ADDRESS:	

RECEIVED

JUL 25 1956

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7770

CERTIFICATE OF DEATH

Reg. Dist. No.

07748

355

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Worcester City</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Snow Hill</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>Road #1</u>	
3. NAME OF DECEASED (Type or print) <u>William Thomas Shortt</u>		4. DATE OF DEATH <u>July 15 1956</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 17 - 1897</u>
9. AGE (In years last birthday) <u>58</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Waldman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self-employed Box Willards, md</u>	
11. BIRTHPLACE (State or foreign country) <u>Willards, md</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>David Shortt</u>		14. MOTHER'S MAIDEN NAME <u>Mary Beaufield</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>219-34-3430</u>	
17. INFORMANT <u>Mrs. Bella Shortt</u> Address <u>Snow Hill, md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized metastases due to</u> <u>177X</u> DUE TO (b) <u>Carcinoma of Prostate Gland</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>2 yrs.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 mos.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan</u> , 1953, to <u>July 15</u> , 1956, that I last saw the deceased alive on <u>July 15</u> , 1956, and that death occurred at <u>10:00</u> A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Benjamin Robins</u> M.D.		DATE SIGNED <u>Benjamin Robins</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>July 18/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Shrine Baptist</u>		22d. LOCATION (City, town, or county) (State) <u>Snow Hill md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter L. Harris</u> ADDRESS <u>Snow Hill, md</u>		24b. REC'D BY REGISTRAR <u>Jul 18 1956</u> DATE	
		24c. REGISTRAR'S SIGNATURE <u>Robert L. Hayward</u>	

1. TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4* may be retained by the hospital or attending physician.

2. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1956 61 700

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

7771

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. 117748
No. 355

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Worster</u>		MARYLAND		STATE <u>md</u>		COUNTY <u>Worster</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>R.D.</u>		LENGTH OF STAY (in this place) <u>14 hrs</u>		CITY (If outside corporate limits write RURAL and give nearest town) TOWN <u>Salisbury - Del.</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Salisbury, Del. R.D. 2</u>				STREET ADDRESS (If rural, give location) <u>R.D. 2</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Aslie Townsend</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>7/15/1956</u>			
5. SEX: <u>male</u>	6. COLOR OR RACE: <u>Caucasian</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): <u>married</u>	8. DATE OF BIRTH: <u>Dec. 26, 1923</u>	9. AGE last birthday: <u>32</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Tobacco</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Truck Driver</u>		11. BIRTHPLACE (State or foreign country): <u>md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME: <u>Lewis C. Townsend</u>				14. MOTHER'S MAIDEN NAME: <u>Estella Collins</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service): <u>yes 1949 to 1950 active 1955 Reserve</u>				16. SOCIAL SECURITY No.: <u>272-12-1027</u>		17. INFORMANT & ADDRESS: <u>Norman Townsend - Salisbury - Del.</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
Immediate cause (a) <u>Shock sec to Heart Tamponade</u>						<u>15 min.</u>	
Antecedent cause(s) (b) <u>Stab wound to left side, heart</u>						<u>15 min.</u>	
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c) <u>Penetrating stab wound.</u>							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OF CONTRIBUTING CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY <u>Home</u>		21c. (City or town) (County) (State) <u>md. Line (Del) Worster md</u>			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>July 15 1956 7 PM.</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>altercation - wife</u>			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>Herman A. Kaplan</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>7/16/56</u> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/>			
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF: <u>7/18/56</u>		NAME OF CEMETERY OR CREMATORY: <u>Taylor State</u>		LOCATION (City, town, or county) (State): <u>Snow Hill - md. R.D.</u>	
DATE REC'D BY LOCAL REG. <u>7/17/56</u>		REGISTRAR'S SIGNATURE: <u>John F. Hayward</u>		24. FUNERAL DIRECTOR: <u>Ronald James - Millboro</u>		ADDRESS: <u>Del.</u>	

OFFICIAL USE - RETURN TO BUREAU

RECEIVED JUL 20 1956

UNITED STATES DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D. C. 20535

BUREAU V. E.

JUL 20 1956

RECEIVED

Handwritten signature

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A19C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

07750

Reg. Dist. No. 350

7754

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Worcester</u>		STATE <u>Maryland</u>		COUNTY <u>Worcester</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Pocomoke City</u>		LENGTH OF STAY (In this place) <u>15 Years</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Pocomoke City</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>906 Cedar Street</u>		STREET ADDRESS (If rural give location) <u>906 Cedar Street</u>					
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Minnie</u>		(Middle) <u>J.</u>		(Last) <u>Tull</u>		(Month) (Day) (Year) <u>July 29 1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>December 12, 1875</u>		9. AGE last birthday <u>80</u> yrs.	10. IF UNDER 1 YEAR (Months) (Days) (Hours) (Min.)	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Edward Collins</u>				14. MOTHER'S MAIDEN NAME <u>Drucilla Adams</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Mrs Roy Lesceallete, Pocomoke, Md</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>Cerebral Hemorrhage - massive</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 hours</u>			
ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.				DUE TO (B) <u>Hypertensive C.V. Disease, mod. severe</u>			
				DUE TO (C) <u>Arteriosclerosis Cerebral & Generalized</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				<u>Obesity, mod. severe</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>6 July, 1956</u> to <u>29 July, 1956</u> , that I last saw the deceased alive on <u>26 July, 1956</u> , and that death occurred at <u>10:30 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>J. E. Sartorius, Jr.</u>				DATE SIGNED <u>2 August '56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>8-1-56</u>		NAME OF CEMETERY OR CREMATORY <u>Nelson Cemetery</u>		LOCATION (City, town, or county) (State) <u>RURAL Pocomoke, Md.</u>	
24. REC'D BY REGISTRAR <u>AUG 5 1956</u>		REGISTRAR'S SIGNATURE <u>Anne White</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Henry S. Watson</u>		ADDRESS <u>Pocomoke, Md.</u>	

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

07751

2411 N. Charles Street, Baltimore

7772 - CERTIFICATE OF DEATH

Reg. Dist. No. 350

Item 7, Film G200, 7/30/56 bh

1. PLACE OF DEATH: COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Maryland</u> COUNTY <u>Worcester</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Stockton</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Stockton</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print)	(First) <u>Emma</u> (Middle) (Last) <u>Ward</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>July 16 1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>widowed</u>	8. DATE OF BIRTH <u>2-10-1882</u> 74 yrs.
9. AGE last birthday		10. UNDER 1 year Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>House</u>	
11. BIRTHPLACE (State or foreign country) <u>Stockton, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Louis Selby</u>		14. MOTHER'S MAIDEN NAME <u>Leah Jane Holland</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS <u>John Ward, Stockton, Md.</u>			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
331X Immediate cause (a) <u>Acute Pulmonary Edema</u>			<u>3 hours</u>
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) <u>Cerebral Vascular Accident</u>			<u>3 weeks</u>
(c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT (Specify) PLACE (Home, farm, factory, street, OF office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)			
HOMICIDE			
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/> HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>July 10, 1956</u> , to <u>July 16, 1956</u> , that I last saw the deceased alive on <u>July 15, 1956</u> , and that death occurred at <u>12:30 P.M. E.S.T.</u> from the causes and on the date stated above.			
SIGNATURE <u>Robert L. LaMar, M.D.</u> (Degree or title)		ADDRESS <u>104 Bay St. Snow Hill, Md.</u> DATE SIGNED <u>7/17/56</u>	
23. BURIAL, CREMATION REMOVAL (Specify)		NAME OF CEMETERY OR CREMATORY	
DATE THEREOF <u>7-19-56</u>		LOCATION (City, town, or county) (State)	
<u>St. Paul M.E. Church, Stockton, Maryland</u>			
DATE REC'D BY LOCAL REG. <u>July 19, 1956</u>		24. FUNERAL DIRECTOR ADDRESS <u>J. Edgar Thomas, Accomac, Va.</u>	
REGISTRAR'S SIGNATURE <u>Anne E. White</u>			

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUL 23 1956

BUREAU V. S.